

SKIP ITEMS 19, 20 AND 21 IF YOU ARE NOT CLAIMING COMPENSATION FOR A SERVICE-CONNECTED DISABILITY. IF YOU RECEIVED ANY TREATMENT WHILE IN SERVICE, COMPLETE THE FOLLOWING INFORMATION (ATTACH TO THIS APPLICATION COPIES OF ANY SERVICE MEDICAL RECORDS YOU HAVE)				
19A. NATURE OF SICKNESS, DISEASE, OR INJURY	19B. TREATMENT DATES BEGINNING DATE ENDING DATE		19C. NAME, NUMBER OR LOCATION OF HOSPITAL, FIRST-AID STATION, DRESSING STATION, OR INFIRMARY	19D. ORGANIZATION/UNIT AT TIME SICKNESS, DISEASE, OR INJURY WAS INCURRED
20. LIST CIVILIAN PHYSICIANS AND HOSPITALS WHERE YOU WERE TREATED FOR ANY SICKNESS, INJURY, OR DISEASE FOR WHICH YOU ARE CLAIMING SERVICE CONNECTION BEFORE, DURING, OR SINCE YOUR SERVICE, AND ANY MILITARY HOSPITALS SINCE YOUR LAST DISCHARGE				
A. NAME	B. PRESENT ADDRESS	C. DISABILITY	D. DATE	
21. LIST PERSONS OTHER THAN PHYSICIANS WHO KNOW ANY FACTS ABOUT SICKNESS, DISEASE, OR INJURY SHOWN IN ITEM 19A, WHICH YOU HAD BEFORE, DURING, OR SINCE YOUR SERVICE.				
A. NAME	B. PRESENT ADDRESS	C. DISABILITY	D. DATE	
IF YOU CLAIM TO BE TOTALLY DISABLED (Complete Items 22A through 25E)				
22A. ARE YOU NOW EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	22B. IF YOU WERE SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED, WHAT PART OF THE WORK DID YOU DO?			
22C. DATE YOU LAST WORKED	22D. IF YOU ARE STILL SELF-EMPLOYED WHAT PART OF THE WORK DO YOU DO NOW?			
23A. EDUCATION (Circle highest year completed) 1 2 3 4 5 6 7 8 1 2 3 4 1 2 3 4 (GRADE SCHOOL) (HIGH SCHOOL) (COLLEGE)			23B. NATURE OF AND TIME SPENT IN OTHER EDUCATION AND TRAINING	
LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR ONE YEAR BEFORE YOU BECAME TOTALLY DISABLED				
24A. NAME AND ADDRESS OF EMPLOYER	24B. KIND OF WORK	24C. MONTHS WORKED	24D. TIME LOST FROM ILLNESS	24E. TOTAL EARNINGS
LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, SINCE YOU BECAME TOTALLY DISABLED				
25A. NAME AND ADDRESS OF EMPLOYER	25B. KIND OF WORK	25C. MONTHS WORKED	25D. TIME LOST FROM ILLNESS	25E. TOTAL EARNINGS
MARITAL AND DEPENDENCY INFORMATION				
26A. MARITAL STATUS (If widowed or divorced, complete Items 26B, 26F and 29A through 29D only) <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NEVER MARRIED (If so, do not complete Items 26B through 30D)				26B. SPOUSE'S BIRTHDATE
26C. NUMBER OF TIMES YOU HAVE BEEN MARRIED	26D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED	26E. IS YOUR SPOUSE ALSO A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES," complete Items 26F, 27C, 27D, 27E, 27F, 27G, 27H, 27I, 27J, 27K, 27L, 27M, 27N, 27O, 27P, 27Q, 27R, 27S, 27T, 27U, 27V, 27W, 27X, 27Y, 27Z)		26F. SPOUSE'S VA FILE NO. (If any) C-
27A. DO YOU LIVE TOGETHER? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "NO," complete Items 27B through 27D)		27B. REASON FOR SEPARATION (For example, marital problems, job requirements, health, etc.)		27C. PRESENT ADDRESS OF SPOUSE
27D. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S SUPPORT MONTHLY \$				
28. CHECK (✓) WHETHER YOUR CURRENT MARRIAGE WAS PERFORMED BY: <input type="checkbox"/> CLERGYMAN OR AUTHORIZED <input type="checkbox"/> PUBLIC OFFICIAL <input type="checkbox"/> OTHER (Explain)				
YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 10.				